Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CHRIS DAVIS, DC

Respondent Name
TRUCK INSURANCE EXCHANGE

MFDR Tracking Number
M4-14-0386-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
SEPTEMBER 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Davis has a peer to peer with Dr. A.J. Bisson who recommended that he proceed with FCE. Also the exam did not require pre-authorization."

Amount in Dispute: $892.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier stands by its reason for denial. Provider has not established that it is entitled to reimbursement for this FCE."

Response Submitted By: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2012	CPT Code 97750-FC (12 units) Functional Capacity Evaluation (FCE)	$892.08	$627.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 119-Benefit Maximum has been reached.
   - 168-No additional allowance recommended.
   - 193-Original payment decision maintained.

Issues

Is the requestor entitled to reimbursement for the FCE rendered on December 26, 2012?

Findings

This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204.

On the disputed date of service, the requestor billed CPT code 97750-FC.

The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

The requestor states in the FCE report that the disputed FCE was claimant's third FCE. A review of the submitted medical bill indicates that the requestor billed for twelve units, which equals three hours; therefore, the requestor did not exceed the three hour limit set in 28 Texas Administrative Code §134.204(g) for discharge FCEs. The respondent did not submit any documentation to support the denial of payment based upon reason code "119".

Per 28 Texas Administrative Code §134.204(g) to determine the reimbursement for FCEs the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

Per 28 Texas Administrative Code §134.203(c)(1)(2), the following formula is used to calculate the Maximum Allowable Reimbursement (MAR): (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = MAR.

The 2012 DWC conversion factor for this service is 54.86.

The Medicare Conversion Factor is 34.0376.

Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 77060 which is located in Houston, Texas; therefore, the Medicare locality is "Houston, Texas."

The Medicare participating amount for CPT code 97750 is $32.43.

Using the above formula, the MAR is $52.27 per unit. The requestor billed for 12 units; therefore, $52.27 X 12 = $627.24. The respondent paid $0.00. The difference between MAR and amount paid is $627.24; this amount is recommended for reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $627.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $627.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.